General Assembly **Substitute Bill No. 6654**

January Session, 2005 *____HB06654INS__032405___*

AN ACT CONCERNING SMALL BUSINESS ACCESS TO HEALTH INSURANCE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivisions (5) and (6) of section 38a-567 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(5) (A) With respect to plans or arrangements issued on or after July 1, 1995, the premium rates charged or offered to small employers shall be established on the basis of a community rate, adjusted to reflect one or more of the following classifications:

[(i) Age, provided age brackets of less than five years shall not be utilized;**]**

[(ii)**]** (i) Gender;

[(iii)**]** (ii) Geographic area, provided an area smaller than a county shall not be utilized;

[(iv)**]** (iii) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall

not be increased by more than five per cent per year;

[(v)**]** (iv) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

[(vi)**]** (v) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259 provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions; and

[(vii)**]** (vi) Family composition, provided the small employer carrier shall utilize only one or more of the following billing classifications: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; **[**and**]** or (VI) employee plus two or more dependents.

(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the small employer group. No small employer carrier may inquire regarding health status or claims experience of the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.

(6) For any small employer plan or arrangement on which the premium rates for employee and dependent coverage or both, vary among employees, such variations shall be based solely on **[**age and other**]** demographic factors permitted under subparagraph (A) of

subdivision (5) of this section and such variations may not be based on health status, claim experience, or duration of coverage of specific enrollees. Except as otherwise provided in subdivision (1) of this section, any adjustment in premium rates charged for a small employer plan or arrangement to reflect changes in case characteristics prior to the end of a rating period shall not include any adjustment to reflect the health status, medical history or medical underwriting classification of any new enrollee for whom coverage begins during the rating period.

Sec. 2. Section 38a-568 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) (1) **[**Subject**]** Except as provided in subdivision (2) of this subsection, and subject to approval by the commissioner, the board shall establish the form and level of coverages to be made available by small employer carriers in accordance with the provisions of subsection (b) of this section. Such coverages, which shall be designated as small employer health care plans, shall be limited to: (A) A basic hospital plan, (B) a basic surgical plan, (C) major medical plans which can be written in conjunction with basic hospital plans or basic surgical plans, (D) comprehensive plans, and (E) plans with benefit and cost-sharing levels which are consistent with the basic method of operation and the benefit plans of health care centers, including any restrictions imposed by federal law. The board shall submit such plans to the commissioner for the commissioner's approval not later than ninety days after the appointment of the board pursuant to section 38a-569. The board shall take into consideration the levels of health insurance provided in Connecticut and such medical and economic factors as may be deemed appropriate and shall establish benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of health insurance provided to small employers. Such plans may include cost containment features including, but not limited to: (i) Preferred provider provisions; (ii) utilization review of health care services, including review of medical necessity of hospital and physician services; (iii) case management

benefit alternatives; and (iv) other managed care provisions.

(2) Notwithstanding the provisions of this section, not later than January 1, 2006, the board shall establish an additional small employer health care plan to be made available by small employer carriers in accordance with the provisions of subsection (b) of this section. Notwithstanding the provisions of this chapter, the additional plan shall be designed to: (A) Offer choices among provider networks of different size; (B) offer different deductibles depending on the health care facility used; (C) use both deductibles and coinsurance; (D) offer prescription drug benefits that use any combination of deductibles, coinsurance and copayments, including, but not limited to, policies and plans that use different combinations at different benefit levels; and (E) offer fewer benefits than required under this chapter. The board may take into consideration the levels of health insurance provided in Connecticut and such medical and economic factors as may be deemed appropriate. Such plans may include the cost containment features set forth in subdivision (1) of this subsection.

[(2)**]** (3) After the commissioner's approval of small employer health care plans submitted by the board pursuant to subdivision (1) or (2) of this subsection, and in lieu of the procedure established by section 38a-513, any small employer carrier may certify to the commissioner, in the form and manner prescribed by the commissioner, that the small employer health care plans filed by the carrier are in substantial compliance with the provisions in the corresponding approved board plan. Upon receipt by the department of such certification, the carrier may use such certified plans until such time as the commissioner, after notice and hearing, disapproves their continued use.

(b) Not later than ninety days after the commissioner's approval of small employer health care plans submitted by the board, each small employer carrier, including, but not limited to, each health care center, shall, as a condition of transacting such insurance in this state, offer those small employer health care plans that correspond to the insurance products being currently offered by the carrier to small

employers. Each small employer that elects to be covered under such plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier.

(c) No health care center shall be required to offer coverage or accept applications pursuant to subsection (b) of this section in the case of any of the following: (1) To a group, where the group is not physically located in the health care center's approved service area; (2) to an employee, where the employee does not work or reside within the health care center's approved service area; (3) within an area, where the health care center reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within that area in its network of providers to deliver services adequately to the members of such groups because of its obligations to existing group contract holders and enrollees; (4) where the commissioner finds that acceptance of an application or applications would place the health care center in an impaired financial condition; or (5) where the commissioner finds that compliance with subsection (b) or (f) of this section would place the health care center in an impaired financial condition. A health care center that refuses to offer coverage pursuant to subdivision (3) of this subsection may not, for ninety days after such refusal, offer coverage in the applicable area to new cases of employer groups with more than twenty-five eligible employees.

(d) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (b) of this section subject to the following conditions: (1) The small employer carrier ceases to market health insurance or health benefit plans to small employers and ceases to enroll small employers under existing health insurance or health benefit plans; (2) the small employer carrier notifies the commissioner of its decision to cease marketing to small employers and to cease enrolling small employers, as provided in subdivision (1) of this subsection; and (3) the small employer carrier is prohibited from reentering the small employer market for a period of five years from

the date of the notice required under subdivision (2) of this subsection.

(e) For groups containing only one member, a small employer carrier or health care center offering coverage pursuant to this section may require proof that the individual has been self-employed for three consecutive months.

(f) Each small employer carrier, including, but not limited to, a health care center, shall offer each health care plan that the carrier makes available to small employers, except association group plans, to all small employers, including, but not limited to, groups containing only one member.

Sec. 3. (NEW) (*Effective October 1, 2005*) Any licensed health insurer or health care center may design and issue health insurance policies or plans that offer flexible benefits designed to reduce health insurance premiums or fees provided such policies or plans meet the requirements of title 38a of the general statutes. Such policies and plans may include, but need not be limited to, policies and plans that: (1) Offer choices among provider networks of different size; (2) offer different deductibles depending on the health care facility used; (3) use both deductibles and coinsurance; or (4) offer prescription drug benefits that use any combination of deductibles, coinsurance and copayments, including, but not limited to, policies and plans that use different combinations at different benefit levels.

Sec. 4. (NEW) (*Effective October 1, 2005*) Not later than January 1, 2006, and annually thereafter, each physician licensed pursuant to chapter 370 of the general statutes shall provide the Insurance Commissioner with a list of the usual and customary fee charged by the physician for office visits and for any medical service or procedure the physician performs. The physician shall file the information on such form as the commissioner prescribes. The commissioner shall compile the data and publish the data on the department's Internet website.

Sec. 5. (*Effective from passage*) (a) Not later than October 1, 2005, the

Insurance Commissioner shall convene a working group to develop a comprehensive provider quality database. The working group shall consist of the Commissioner of Public Health, the Commissioner of Health Care Access, health care providers and consumers, representatives of health insurers and health care centers licensed in this state, and representatives of employers that provide health insurance to residents of this state.

(b) The working group shall examine the information collected from providers and disseminated to the public pursuant to the physician profile created under section 20-13j of the general statutes. The working group shall examine (1) whether additional information should be collected and disseminated, and (2) what other mechanisms are available or may be created to provide greater public information about the level of expertise of individual providers in this state.

(c) Not later than February 1, 2006, the Insurance Commissioner shall submit a report on the working group's findings to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health in accordance with section 11-4a of the general statutes.

Sec. 6. Subdivision (7) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(7) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract and does not include (A) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of

specified disease or limited benefit health insurance, provided that the carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by **[**age,**]** gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

Sec. 7. Subdivision (27) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(27) "Case characteristics" means demographic or other objective characteristics of a small employer, including **[**age,**]** sex, family composition, location, size of group, administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259 and industry classification, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of sections 38a-564 to 38a-572, inclusive.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2005*	38a-567(5) and (6)
Sec. 2	*October 1, 2005*	38a-568
Sec. 3	*October 1, 2005*	New section
Sec. 4	*October 1, 2005*	New section

Sec. 5	*from passage*	New section
Sec. 6	*October 1, 2005*	38a-564(7)
Sec. 7	*October 1, 2005*	38a-564(27)

INS *Joint Favorable Subst.*